

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155328	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/26/2014
NAME OF PROVIDER OR SUPPLIER WESTPARK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00IN152915, Complaint IN00155302, and Complaint IN00155321.</p> <p>Complaint IN00152915 - Unsubstantiated, due to lack of evidence.</p> <p>Complaint IN00155302 Substantiated, no deficiencies related to the allegations are cited.</p> <p>Complaint IN00155321 - Unsubstantiated, due to lack of evidence.</p> <p>Survey dates: August 24, 25, and 26, 2014</p> <p>Facility number: 000221 Provider number: 155328 AIM number: 100267620</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF/NF: 85 Total: 85</p> <p>Census payor type: Medicare: 18 Medicaid: 54 Other: 13 Total: 85</p> <p>Sample: 4</p> <p>Westpark Rehabilitation Center was found to be in compliance with 42 CFR Part 483 Subpart B</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155328	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/26/2014
NAME OF PROVIDER OR SUPPLIER WESTPARK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 and 410 IAC 16.2 in regard to the Investigation of Complaint IN00152915, Complaint IN00155302, and Complaint IN00155321. Quality Review 08/27/14 by Lisa McColly	F 000			